Lauren Dvorscak, MD

Licensed Physician #MD2014-0976

Issue Date	Expiration Date
12/08/2014	07/01/2015

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Lauren Dvorscak, MD

License Number: MD2014-0976

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 12/08/2014 Date Expires: 07/01/2015*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

THE NEW MEXICO MEDICAL SOCIETY

NMHHSA New Mexico Hospitals & Health Systems Association

First Perm

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The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

Date of Application: 10 Oct 2014 **Application Fee:** 400.00

Exam

Demographics

Legal Name	Dvorscak (Last)	Lauren (First)	E (Middle)

Other Names Used	

Will you be applying by endorsement Yes ____ No X
(See page 2 of the application instructions for requirements)

Gender M (F)	**Place of Birth** Munster, Indiana	**Citizenship** USA	
Immigration Status	N/A	**INS Certification #**	N/A
***Social Security Number**	[redacted]	**Date of Birth**	[redacted]-1984
***NM Tax ID# (if applicable)**		Pending ☐	
***Fed. Tax ID# (if applicable)**		Pending ☐	
Current Practice Name	University of New Mexico Hospitals - Pathology Dept.		
Practice Limited to: (Clinical Specialty)	Resident in training		
Street	MSC 08 4640 BMSB RM 335, 1 University of New Mexico		
City	Albuquerque	State NM	Zip Code 87131
Telephone Number	(505) 272-4814	Facsimile	(505) 272-8084
*Office Manager or Contact Person:			
Foreign Languages (spoken fluently by practitioner)			
Foreign Languages (spoken fluently at Practice)			
***E-Mail Address** (confidential)	[redacted]@gmail.com		
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)			
*Street	[redacted]		
*City	[redacted]	Code	87120
Telephone Number	(219) 796-4959	Facsimile	
What are your immediate or future Practice Plans in New Mexico?	Fellowship in forensic pathology		
Home Ad	[redacted]		
Street			
*City			-120

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)

Other Practice Locations (If Applicable)					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education					
College or University	Indiana University - Northwest				
City	Gary	State/Country	IN	Zip Code:	46408
Dates Attended From:	8/2003 To: 5/2007	Degree	BS	Graduation Date	5/2007
College or University					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Degree		Graduation Date	
Professional / Medical Education					
College or University	Indiana University School of Medicine				
City	Indianapolis	State/Country	IN	Zip Code:	46202
Dates Attended From:	8/2007 To: 5/2011	Degree	MD	Graduation Date	5/2011
College or University					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Degree		Graduation Date	

Internship/ Residency/ Fellowship					
Institution Name	University of New Mexico (Department of Pathology)				
City	Albuquerque	State/Country	NM	Zip Code:	87131
Dates Attended From:	6/2011 To: Present	Field	Pathology		
Institution Name					
City		State/County		Zip Code	
Dates Attended From:	To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Field			
Institution Name					
City		State/Country		Zip Code:	
Dates Attended From:	To:	Field			

Applicant Name Lauren E Dvorscak Date 10 Oct 2014

Work History Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			
Location		From		To	
Street		Phone Number			
City		State		Zip Code	
Type of Practice		Contact Person			
Type of Discharge		Rank Achieved			

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Hospital and Health Facility Affiliation History (other than postgraduate training) ☒ **N/A**

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number			Facsimile		
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Applicant Name Lauren E Dvorscak **Date** 10 Oct 2014

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title	Ian Paul, MD, Residency program director				
Address	MSC 08 4640 BMSB 335, 1 University of New Mexico				
City	Albuquerque	State	NM	Zip Code	87131
Telephone Number	(505) 272-3480	Facsimile	(505) 272-8084		
(2) Name and Title	Van Samedi, MD, PhD, Associate Professor of Pathology				
Address	MSC 08 4640 BMSB 335, 1 University of New Mexico				
City	Albuquerque	State	NM	Zip Code	87131
Telephone Number	(505) 272-3481	Facsimile	(505) 272-8084		
(3) Name and Title	Therese Bocklage, MD, Professor of Pathology				
Address	MSC 08 4640 BMSB 335, 1 University of New Mexico				
City	Albuquerque	State	NM	Zip Code	87131
Telephone Number	(505) 272-8071	Facsimile	(505) 272-8084		

Applicant Name Lauren E Dvorscak **Date** 10 Oct 2014

Licensure-Registration-Certification Information

ECFMG Number (if applicable)							
State Professional License/Certification Number					RS2011-0345		
State	NM	Issue Date	6/23/2011	Expiration Date	7/1/2015	Pending	☐
All Other State License Numbers (regardless of status - attach separate list if necessary.)							
State	**Number**	**Issue Year**	**Expiration Date**				
***Federal Drug Enforcement Admin. (DEA) Registration**						N/A	☒
Number		Exp. Date				Pending	☐
***State Controlled Substance Registration** (CSR)						N/A	☒
Number		State		Exp. Date		Pending	☐
***Medicare Unique Physician Identification Number (UPIN)**							
Pending ☐							
***State Medicaid Provider Number**							
Pending ☐							
***National Provider Identification Number**					1316236011		
Pending ☐							

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MEDICAL STAFF

Specialty Board Certifications ☒N/A

Are you Board Certified? ☐Yes ☐No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?		Yes No	
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☐ Yes ☐ No

Current Carrier				Current ☐	Pending ☐
Address					
Dates Insured	From	To	Policy #		
			Coverage Limits		

Applicant Name Lauren E Dvorscak **Date** 10 Oct 2014

Licensing Exam: Please check all that apply:

☐ **State Board Exam (Prior to 1973)** Which state? _____ Date(s) passed? _____

☐ **FLEX** ☐ **LMCC** ☐ **National Board (NBME)** ☒ **USMLE**

Part/Step 1 Date Passed_____ Month/Year Part/Step 2 Date Passed_____ Month/Year Part/Step 3 Date Passed_____ Month/Year

Professional Practice Questions

Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☒
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☒
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☒
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☒
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☒
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☒
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☒
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒

Applicant Name Lauren E Dvorscak **Date** 10 Oct 2014

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☐	No ☒
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☒
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	Yes ☐	No ☒
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐	No ☒
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☒
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☒
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☒
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☒
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☒

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, Lauren E Dvorscak, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

ATTACH RECENT PASSPORT-

Lauren E Dvorscak — Applicant Signature

10 Oct 2014 — Date

aph taken within six months prior to filing the application, approximate size 2 x 2 inches, ace, front view, plain white or off-white background, standard photo stock paper, scanned raphs should have no visible pixels or dots.

Applicant Name Lauren E Dvorscak **Date** 10 Oct 2014

AMA Physician Profile

Name and Mailing Address
LAUREN E DVORSCAK MD
[redacted]

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Birth date [redacted]/1984

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

Self-designated practice specialty ANATOMIC/CLINICAL PATHOLOGY (primary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
None	Reported				

Current and/or historical medical school

IN UNIV SCH OF MED, INDIANAPOLIS IN 46202

Degree Awarded: Yes

Degree Year: 2011

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: UNIV OF NM SCH OF MED
Sponsoring State: NEW MEXICO
Program name: UNIVERSITY OF NEW MEXICO PROGRAM
Specialty: ANATOMIC/CLINICAL PATHOLOGY
Dates: 07/2011 - 06/2015 (Verified)

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
NEW MEXICO	MD	06/23/2011	07/01/2015	ACTIVE	RESIDENT	10/16/2014

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at ***https://cvsonline2.ecfmg.org/***

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
None	Reported			

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate type:

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Adminstration or the US Public Health Service.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Additional Information

To date, there is no additional information for this physician on file.

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website **(www.ama-assn.org/go/amaprofiles)** and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:11/12/2014

PRACTITIONER INFORMATION

Name:	Lauren E Dvorscak
DOB:	[redacted]984
Medical School:	Indiana University School of Medicine Indianapolis Indianapolis, Indiana, UNITED STATES
Year of Grad:	2011
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
NEW MEXICO	RS2011-0345	6/23/2011	7/1/2015	9/17/2014

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

New Mexico Medical Board
2055 S. Pacheco, Building 400
Santa Fe, NM 87505
505-476-7220 fax 505-476-7237
(toll free within New Mexico 800-945-5845)

General Information

Licensee	Lauren Dvorscak	License Type	Resident
Business address	MSC11 6093	License Number	RS2011-0345
Business address	1 UNM	License Status	Active
Business city state zip	Albuquerque NM 87131	License Date	06/23/2011
Business phone	None	**License Expires	07/01/2015

Medical School	Indiana Univ SOM Indianapolis
Graduation Date	05/31/2011

* The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: www.abms.org to determine if the physician has earned a specialty certification from this private agency.

** A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed.A lapsed license is not valid for practice in New Mexico.

PUBLIC ACTIONS:None
(while licensed in New Mexico)
New Search

This Board's data has been searched 476047 times since 05/08/2001
Date information last updated: 11/11/14

Please read the AIM **Disclaimer**

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Lauren E Dvorscak Date of Birth [redacted] /1984

Print or Type Name: Lauren E Dvorscak Soc Sec # [redacted]

Other Name(s) _____

Name of Medical School: Indiana University School of Medicine

Address: 635 Barnhill Dr., MS160 City Indianapolis State IN Country USA

DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL INSTRUCTIONS:

Please complete this form and forward it DIRECTLY to NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Please include dean's letter (if available) and a **COPY OF THE OFFICIAL TRANSCRIPT** (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations).

APPLICANT'S EDUCATIONAL DEGREE AND DATE AWARDED HISTORY
If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	Dvorscak (Last Name)	Lauren (First Name)	E. (MI)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/13/2007	05/09/2008	06/01/2010	05/15/2011
	08/11/2008	05/08/2009	___/___/___	___/___/___
	06/16/2009	05/21/2010	___/___/___	___/___/___

The applicant attended 169 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and:

Check One

✓ Was awarded a degree in Medicine on 05/15/11 (mm/dd/yr)

___ Was NOT awarded degree. Please explain reasons(s): _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. ***All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.***

1. Did the applicant take any leaves of absence or breaks from his/her medical education? ___Yes X No
2. Was the applicant ever placed on probation? ___Yes X No
3. Was the applicant ever disciplined or under investigation? ___Yes X No
4. Were any negative reports ever filed by instructors regarding the applicant ? ___Yes X No

COMMENTS:_____

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NM MEDICAL BOARD

AFFIX INSTITUTIONAL SEAL HERE

Signature: Sheryl E. Allen, MD, MS

Print Name: Sheryl E. Allen

Title: Associate Dean

Date: 10/23/14

International medical schools **must** attach a copy of the medical school diploma and a transcript or provide and explanation.

This form *will not be accepted* unless it is stamped with the institutional seal.
Thank you for helping us process this application for licensure.

Indiana University School of Medicine
635 Barnhill Drive
Indianapolis, Indiana 46202-5120

Academic Record

Name: Lauren E Dvorscak
University ID: 0000406998
Date: 10-20-2014

Graduated with Doctorate in Medicine - 5/15/2011

Academic Year	Center	Course/Credit	Title	Grade	Enrollment	% Distribution of Grades* H	HP	P	F
I Aug 13 07-May 09 08	NORTHWEST	P610/6	MOLECULAR BASIS OF MED	H	18	17	44	39	0
		P620/12	HUMAN STRUCTURE	H	18	33	33	33	0
		P631/6	SYSTEMIC FUNCTION	H	18	28	56	17	0
		P641/6	NEURAL CONTROL & DISEASE	H	18	28	22	50	0
		P645/6	MEDICATIONS AND DISEASE	H	18	33	33	28	6
		P661/4	PATIENT/DOCTOR RELATIONS	P	18	0	0	100	0
II Aug 11 08-May 08 09	NORTHWEST	P650/11	INVASION AND DEFENSE	HP	18	17	50	33	0
		P662/28	PATHOPHYSIOLOGY	H	18	33	22	44	0
		X672/1	BIOSTATISTICS	H	18	44	33	22	0
III Jun 16 09-May 21 10	NORTHWEST	M720/8	MEDICINE CLERKSHIP	HP	301	19	50	29	2
		N720/4	CORE CLKSHP-NEUROSENSORY	HP	302	23	34	43	0
		N730/4	PSYCHIATRIC CLERKSHIP	H	303	26	51	23	0
		G730/5	OBSTETRICS AND GYNECOLOGY	HP	297	20	29	48	1
		S700/9	SURGERY CLERKSHIP	HP	296	8	48	42	0
		L704/2	ANESTHESIA CLERKSHIP	H	296	29	35	36	0
		K710/8	PEDIATRICS CLERKSHIP	HP	299	21	41	37	1
		Y730/4	FAMILY MEDICINE CLERKSHIP	HP	303	23	40	37	0
		45ZI701/4	ADVANCED MED PROB SOLVING	H	33	97	3	0	0
IV Jun 01 10-May 31 11		93CA990/4	SP ELEC PATH	H	13	77	15	8	0
		49CA744/4	PATHOLOGY	H	11	73	27	0	0
		93SG990/4	SP ELEC SURGERY	H	22	82	9	9	0
		45MI691	Sub-I Medicine Northwest	HP	94	11	48	40	0
		93CA810/4	FORENSIC PATH	H	14	100	0	0	0
		93AN990/4	SP ELEC ANES	HP	18	39	39	22	0
		R720/4	CORE CLERKSHIP - RADIOLOGY	HP	296	12	67	20	0
		93CA990/4	SP ELEC PATH	H	13	77	15	8	0
		X720/4	EMERGENCY MEDICINE CLERKSHIP	HP	298	6	39	54	0

* Percentage totals may not sum to 100 because of rounding Courses X600 (first year) and X802 and 93ZH820 (fourth year) are pass/fail

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

POSTGRADUATE TRAINING VERIFICATION

I am applying for a license to practice medicine in New Mexico and the Medical Board requires this form to be completed by each hospital where I participated in an approved postgraduate training program in the United States or Canada. This is your authorization to release any information in your files of record, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505. Your prompt response will be appreciated.

Name: Lauren E Dvorscak M.D.

Lauren E Dvorscak — 10 Oct 2014
Signature — Date (Month/Day/Year)

(DO NOT DETACH)

This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) an approved postgraduate training program in the United States or Canada.

This is to certify that LAUREN J DVORSCAK, M.D. undertook and satisfactorily completed a full term approved program of 48 (number) months in the UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER MSC 11 6093, 1 UNM ALBUQ NM 8713 (Full name and complete address of facility) in the field of PATHOLOGY from 6/23/2011 (Date: Mo/Day/Yr) to 6/30/2015 (Date/Anticipated Date) An

1. Was this program approved for postgraduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada? ✓ **Yes** ___ **No**
2. Was applicant ever placed on probation, restricted, or limited? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
3. Was there any reason not to continue applicant in the training program? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
4. Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.

   Ability to practice medicine is to be construed to include all of the following:

   The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

   The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids

   "Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition and alcoholism.

5. Was the applicant ever diagnosed with or treated for bipolar disorder, schizophrenia, paranoia, or any psychotic disorder? ___ **Yes** ✓ **No** If ***yes***, please attach written explanation.
6. Were applicant's final evaluations in every category rated satisfactory? ✓ **Yes** ___ **No** If ***no***, please attach written explanation.

Joy Sparkman — 10/15/14
Printed name of person completing this form — Signature — Date

Signature of Notary (if applicable) — Date

My commission expires: _____

If there is no hospital or notary seal, this form is unacceptable.
Please return this form directly to the address above
Thank you for your cooperation.

New Mexico Medical Board

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : **10/14/2014**

Recipient:

New Mexico Medical Board
ATTN: Amanda Quintana, Licensing Director
2055 S Pacheco
Building 400
Santa Fe, NM 87505

RS 2011-0345

Examinee: Dvorscak, Lauren
Alt Name(s): Dvorscak, Lauren E

Examinee ID#: 5-226-894-3
Date of Birth: [redacted]1984

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	05/23/2009	Pass	248	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	10/16/2010	Pass	257	(189)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	01/04/2011	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
CALIFORNIA	12/19/2011	Pass	231	(190)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

10/23/2017

Dvorscak, Lauren **Medical Doctor** **MD2014-0976**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	04/24/2017
2. Since your last renewal have you been denied professional liability insurance coverage?	N	04/24/2017
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	04/24/2017
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	04/24/2017
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	04/24/2017
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	04/24/2017
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	04/24/2017
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	04/24/2017
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	04/24/2017
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, for any reason, except for medical records delinquency unrelated to your professional	N	04/24/2017
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	04/24/2017
10. c. Since you last renewal, have you been investigated and/or terminated by a healthcare entity for cause, or without cause, related to your clinical competence or conduct, which could impact patient safety/care, or allowed to resign in lieu of termination for such reason?	N	04/24/2017
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	04/24/2017
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	04/24/2017
12. b. Are any currently held licenses pending investigation or being challenged?	N	04/24/2017
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	04/24/2017
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, or restricted?	N	04/24/2017
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	04/24/2017
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	04/24/2017
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	N	04/24/2017
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and	N	04/24/2017
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC	Y	04/24/2017
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	04/24/2017
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	04/24/2017
21. Are you currently in arrears in payments of amounts required to be paid pursuant to an outstanding judgement and order for child support in New Mexico or in any other state?	N	04/24/2017